INTERIM STUDY COMMITTEE ON MEDICAID OVERSIGHT

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MEETING MINUTES[1]

Meeting Date:	**August 25, 2000**
Meeting Time:	**10:30 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 404**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**2**

Members Present: **Rep. William Crawford, Chair; Rep. Charlie Brown; Rep. Susan Crosby; Rep. Mary Kay Budak; Rep. Gary Dillon; Rep. Dave Frizzell; Sen. Patricia Miller, Vice-Chairperson; Sen. Marvin Riegsecker; Sen. Vi Simpson; Sen. Rose Antich; Sen. Samuel Smith, Jr.**

Members Absent: **Sen. Robert Meeks.**

The second meeting of the Interim Study Committee on Medicaid Oversight was called to order at 10:40 a.m. by Rep. William Crawford, Chair.

EDS Update

Ms. Mary Simpson, EDS, provided a handout (Exhibit 1) depicting selected statistics to the Committee. Statistics included the number of Medicaid claims paid and denied and the top four reasons for claim denials. The top four reasons included the following: duplication of another claim (5,001 denials during SFY 2000); recipient was enrolled in the Risk-Based Managed Care (RBMC) portion of the Hoosier Healthwise program (2,017 denials); a claims correction form (CCF) was not returned with proper corrections within 45 days (499 denials); and the service was not payable because the recipient had not satisfied the spenddown requirement for the month (388 denials). Other statistics included enrollment and recipient data by county and by region for all dentists, as well as pediatric dentists, as of July 2000.

Asked what represents successful participation rates by providers, Ms. Kathy Gifford, Assistant

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Secretary for the Office of Medicaid Policy and Planning (OMPP), stated that the state's criterion is that Medicaid recipients are receiving care and services. She added that OMPP has reported previously on member access and that the trends are good, but they could be better.

Rep. Charlie Brown requested additional information of Ed Popcheff (Indiana Dental Association) and Ms. Gifford as to how many dentists are doing business in each county. Asked as to whether there are recipients who are calling in to the state who are not receiving services, Ms. Gifford responded that she believes the number who are not receiving services is going down, but she will provide additional information on the phone call volume to the Committee.

Asked whether payments to dental providers are up-to-date, Ms. Simpson responded that there is a 24-hour turnaround on the processing of paper claims, while electronic claims are processed immediately.

Asked why there are so few pediatric dentists, Mr. Popcheff responded that pediatric dentistry is a very small specialty area and is not replenishing itself. After an individual receives a dental degree, a dentist must go back to school for post-doctoral work. He estimated that four to six pediatric dentists graduate each year in Indiana with about half leaving to practice out of state. Mr. Popcheff added that there are currently no state incentives for pediatric dentists, but there are some federal dollars. Asked as to whether there is a shortage of dentists in Indiana, Mr. Popcheff responded that the problem is more of a distributional problem within the state. Mr. Popcheff indicated that he would try and provide additional information to the Committee regarding how Indiana compares to other states in the number of pediatric dentists. He also indicated that there is continual improvement in the number of dentists enrolling in the Medicaid program and that about 200 dentists per month are being contacted and encouraged to enroll in the program.

Sen. Miller suggested the following reasons for low dental provider enrollment in the Medicaid program: (1) there is still a trust factor with respect to provider reimbursement; (2) a reluctance to deal with the potential hassles involved in working with the Medicaid program; and (3) many Medicaid patients are not very reliable in showing up for dental appointments.

Rep. Brown inquired as to whether actions taken by a dental office to increase the number of recipients who show up for their appointments are considered a reimbursable activity. Ms. Gifford responded that those actions are not reimbursed separately, but they might be included under overhead expenses. Asked as to whether the problem with specific reimbursement was a state or a federal issue, Ms. Gifford indicated that she was not sure but that, in either case, it would be an administrative nightmare. Mr. Popcheff added that he thought that it was likely a problem with the Health Care Financing Administration (HCFA).

Long Term Care Issues

Staffing Levels. Ms. Faith Laird, Vice President for Regulatory Affairs, Indiana Health Care Association (IHCA), introduced the first of two issues: staffing levels in nursing facilities. Ms. Laird provided two articles to the Committee from the Journal of the American Medical Association: "The Decreasing Supply of Registered Nurses" (Exhibit 2) and "Implications of an Aging Registered Nurse Workforce." (Exhibit 3). Ms. Laird had also provided documents to the Committee in advance of the meeting: (1) a memorandum to two Workgroups of the Governor's Task Force on Medicaid Waivers; (2) an article from The Oregonian regarding the state of the long term care industry; (3) an article from The Minneapolis Star-Tribune regarding staffing shortages in nursing homes; and (4) an executive summary of the HCFA report to Congress on appropriateness of nurse staffing ratios in nursing homes (see Exhibit 4).

Ms. Laird stated that the most pressing concern in the nursing home industry currently is

staffing. The supply of nurses has historically been cyclical. Ms. Laird, however, indicated that a cyclical supply may no longer be true. She added that the average age of the nursing workforce has increased due to several reasons: (1) a decline in the popularity of nursing as a career; (2) alternative employment possibilities; (3) the high level of stress in the nursing profession; and (4) the threat of personal liability. Ms. Laird added that options that might potentially improve the supply of nurses include the following: (1) higher wages; (2) tuition forgiveness; and (3) more aggressive recruiting of nurses from outside Indiana.

Ms. Laird indicated that the industry feels threatened by federal initiatives to require specific minimum staffing levels. She added that if minimum staffing levels are mandated, there would be a significant impact on nursing facilities, both in terms of non-compliance by facilities and from the financial impact. Ms. Laird also stated that the costs of liability insurance have been skyrocketing with a 500% increase over recent rates. Although these are allowable costs for Medicaid reimbursement, the problem is one of cash flow.

Ms. Laird indicated that the statewide average wage rates for certified nurse aides (CNA's) is about $8.55 per hour, $18.38 per hour for registered nurses, and $14.69 per hour for licensed practical nurses.

Ms. Gifford noted that the case-mix reimbursement system is a median-based system. Consequently, if nursing facilities pay more for wages and salaries, the reimbursement system will also pay more to the facilities.

Ms. Laird raised the issue of a wage pass-through whereby additional Medicaid reimbursement is provided to nursing facilities specifically for increasing the wages of certain staff. Ms. Laird indicated that this is being done in several other states, usually due to a legislative mandate. She also indicated that, in return, nursing facilities must open their books to the state and that the increased dollars must go directly toward wages and benefits.

Rep. Brown questioned what has happened in recent years because it was only about four years ago that there was an ample supply of nurses. Sen. Miller responded that the issue is what those nurses are doing and what career choices they are making. She added that nursing students may be influenced at the academic level to go into career areas such as advanced practice nursing and Ph.D.-level nursing. Sen. Miller indicated that the numbers of nursing students are not as much the issue as is where the nurses choose to work. Ms. Laird added that there are about 74,000 nurses who renew their licenses each year, but only about 38,000 are in active practice.

The Committee requested staff to provide an outline of what legislative options may exist with respect to nursing staff shortages.

Adult Foster Care and Assisted Living. Ms. Laird also discussed a second issue regarding the funding of "adult foster care" and "assisted living" services through the Medicaid waiver program. Ms. Laird expressed the following concerns: (1) the primary consultant hired by OMPP, Dick Ladd, potentially has a conflict of interest; and (2) the program will be designed similar to an Oregon program that IHCA believes has not yet been studied closely enough. Ms. Laird further stated that the process OMPP is using to design the program is flawed, especially with respect to the short time frame required for submitting a waiver to HCFA.

Ms. Kathy Gifford, OMPP, stated that the legislation mandates that the waiver be submitted to HCFA by October 1, 2000. Ms. Gifford distributed a document outlining the time line being used in developing the waiver application and amendment to the Aged and Disabled Waiver (see Exhibit 5).

Sen. Miller expressed some concerns about the process, as well, especially with respect to representation and when providers and advocacy groups were brought into the process. Ms. Gifford indicated that the task force was broadly represented and that the process had a very limited time frame. Ms. Gifford added that she did not believe that anyone got an unfair head start on the process. Ms. Gifford stated that she would provide the Committee with additional information regarding the process by the next meeting.

Mr. John Cardwell, Citizens Action Coalition of Indiana, chaired one of the task forces and confirmed that much work had been accomplished in a short amount of time. He also stated that all parties had come into the process at the same time. Mr. Cardwell stated that the task force consisted of five people appointed by the Governor; was allowed to meet away from the State House but was publicly advertised; took much input; and looked primarily at the Washington and Oregon models. He also stated that Dick Ladd has been one of the preeminent consultants in the country with respect to assisted living and adult foster care.

Mr. Jim Leich, Indiana Association of Homes for the Aging, also stated that the process had been a good one albeit short on time. Mr. Leich stated that he feels confident about progressing with the assisted living portion but, perhaps, not quite so confident about the adult foster care provisions. Mr. Leich added that there was not enough time for developing quality assurance provisions.

Responding to a question from the Committee, John Cardwell stated that the resulting plan was, although heavily influenced by the Oregon model, really a hybrid of different models and that the Family and Social Services Administration (FSSA) staff has expressed interest and a willingness to continue working on the plan.

Medicaid Reimbursement Levels - Medicaid Waiver Reimbursement Rates

Ms. Melissa Durr, Executive Director of the Indiana Association of Area Agencies on Aging (AAAs), provided written testimony to the Committee (see Exhibit 6). She discussed three main areas of concern: (1) the rate setting process - no formal process exists for setting reimbursement rates for Medicaid waivers; (2) low Medicaid waiver reimbursement rates have resulted in a lack of service providers; and (3) low reimbursement rates do not reimburse AAAs adequately for time spent on Medicaid waiver clients - AAAs manage the waiting list, provide all activities necessary to move a person from the list and into services such as client visits, obtaining forms from the doctor, as well as other activities. Ms. Durr asked the Committee to give strong consideration to establishing a process for Medicaid waiver reimbursement rate setting that is both fair and timely.

Responding to a question from the Committee, Ms. Durr stated that the low Medicaid waiver reimbursement rates have resulted in fewer service providers in three ways: (1) providers going out of business; (2) providers refusing to accept Medicaid waiver clients; and (3) providers only accepting waiver clients if guaranteed a minimum number of hours.

Medicaid Reimbursement Levels - Hemophilia Drug Products

Mr. Steve Bassett, Executive Director of Hemophilia of Indiana, Inc., provided background information on the development of hemophilia products and the recent reduction in Medicaid reimbursement for those products. He urged the adoption of an immediate moratorium on the reimbursement changes while the issue is examined and an equitable solution is reached (see Exhibit 7 for Mr. Bassett's written testimony).

Mr. Ron Ferguson, Option Care, Inc., a home health care provider in Indianapolis, provided a

document to the Committee regarding "Gravity Antibiotics" (See Exhibit 8).

Mr. Jim Rickter, HemaSource, provided a copy of his testimony to the Committee (Exhibit 9). Mr. Rickter stated that HemaSource is a specialty pharmacy providing blood clotting factor to patients with hemophilia. He claimed that the recent change in Medicaid reimbursement resulting from the lowering of the benchmark average wholesale price (AWP) for approximately 400 drugs has created a situation where Medicaid reimbursement is now less than acquisition cost. Mr. Rickter added that if the reimbursement situation is not corrected, home health care providers who support the patient in their home will be forced to withdraw, leaving the patient little alternative but to seek care as an inpatient or in an emergency room. Mr. Rickter also stated that several other states facing the same situation have used a variety of emergency mechanisms, including the deferral of the new rates while the issue is being examined.

Ms. Kathy Gifford, OMPP, provided the Committee with background information about the drug reimbursement issue (see Exhibit 10). Ms. Gifford's testimony included a description of the methodology previously used for determining the Medicaid reimbursement rate which was equal to average wholesale price (AWP) less 10%. She told of the investigation and subsequent conclusion by the National Association of Medicaid Fraud Control Units (NAMFCU) and the U.S. Department of Justice that some drug manufacturers were overstating their AWP levels. Consequently, AWPs (and ultimately reimbursement rates) were lowered for about 400 drugs, including the blood clotting factors required for individuals with hemophilia. Ms. Gifford added that OMPP has surveyed the nine Indiana Medicaid providers that have been supplying blood factors to determine their actual acquisition costs and the providers were either hesitant to, or refused to, release that information. She added that OMPP is continuing to try and determine if reimbursement modifications are necessary.

Ms. Jill Moberly, a consumer of blood factor products from Bloomington, IN, stated that she has hemophilia. She passed around a bottle containing Antihemophilic Factor/von Willebrand Factor Complex. Ms. Moberly stated that she can not depend on going to an emergency room each time she has a problem for reasons that include slow response in emergency rooms, emergency room physicians not always being familiar with her particular bleeding disorder, and hospitals not always having the entire array of blood factor products in stock. She added that having the blood factor at home allows her to treat herself and allows her to continue working. Ms. Moberly stated that the cost of the blood factor is about $8,000 per dose for each of her episodes.

Mr. Carl Weixler stated that he, as well as his daughter, were also consumers of blood factor products. He stated that he considered having to receive the blood factor product in a hospital setting to be a life-threatening situation for the reasons mentioned above. He also stated that this is a major issue for the hemophilia community.

Ms. Diana Mumaw, representing APEX Therapeutic Care, Inc., provided a set of documents to the Committee (Exhibit 11). Included in the documents are the following: (1) a copy of her written testimony; (2) position papers from the National Hemophilia Foundation and the Hemophilia Federation of America; and (3) letters from two consumers, Ms. Judy Brannon and Mr. Weixler.

Ms. Glenna Gebauer told of her experience suffering from hemophilia. She told of the bleeding problems she encountered after having her tonsils removed, after having teeth pulled, and especially after child birth. She told of losing health insurance as a result of her expensive condition until she was finally allowed onto the Indiana Comprehensive Health Insurance Program. She also stated that the average cost of a surgery for her is about $250,000. She urged the Committee to do whatever was necessary to keep home health care as an option for her.

A letter prepared by Mr. Gregory Warren of Wyeth-Ayerst Laboratories to OMPP was distributed to the Committee (see Exhibit 12). The letter is a request that OMPP adjust the Medicaid reimbursement formula as a result of the new lower AWP pricing method.

The Committee requested additional information from staff as to what options are available to the state that could lessen the impact of the recent changes in reimbursement rates on Medicaid clients and health care providers.

Rep. Brown moved that the Committee send a letter to the Legislative Council urging the Council to contact Governor O'Bannon and to request that the Governor declare a moratorium on the rate decrease. The motion was seconded and passed by a voice vote of the Committee members (see Exhibit 13 for letter).

Medicaid Waivers

Ms. Penny Lewis, CEO and President of the Brain Injury Association of Indiana, introduced the issue of Medicaid waivers, especially with respect to the Traumatic Brain Injury (TBI) waiver. Ms. Lewis provided the Committee with background information on the Traumatic Brain Injury waiver that was implemented on January 1, 2000 (see Exhibit 14). She noted a couple of problems with the TBI waiver: (1) During the appeal process, the case manager is not allowed to work with the family because it is deemed a conflict of interest; and (2) she often has trouble getting a direct and/or consistent answer from FSSA on questions dealing with implementation issues surrounding the waiver. Rep. Crawford requested that OMPP provide a written response to Ms. Lewis' testimony.

Also, a letter from Ms. Lewis outlining her concerns with the TBI waiver program was provided to Committee members in advance of the meeting (see Exhibit 15).

FSSA distributed a document to the Committee prepared by the Indiana Governor's Planning Council for People with Disabilities. The document is entitled Indiana Medicaid Home and Community-Based Waiver Services: A Guide for Consumers, June 1, 2000 (see Exhibit 16).

Expiring Legislation

Medicaid Reimbursement in Hospital Emergency Rooms - Ms. Kathy Gifford, OMPP, briefly described the requirement provided in the Balanced Budget Act of 1997 that imposes the "prudent layperson standard" on Medicaid programs. If a prudent layperson would believe that an emergency situation existed with a patient then the Medicaid program must provide for reimbursement of any emergency services provided to that patient, even if it was later determined that no emergency existed. She added that these particular concepts should be pretty clear to everyone.

Tom Gutwein, MD, American College of Emergency Physicians, stated that Medicaid recipients comprise about 15% of the Indiana population. However, as an emergency room physician, he treats everyone in the same manner without knowledge of the patient's insurance. He added that the RBMC program is where they have the most problems. Dr. Gutwein asked the Committee for continued support of the emergency room reimbursement legislation with the additional application to the RBMC program.

Mr. Mike McKinney, Medical Director for Managed Health Services (MHS), one of the Medicaid managed care providers in Indiana, stated that there now should be no problem with prior authority. He reiterated that the "prudent layperson standard" does apply and that MHS must reimburse based on the emergency services provided and not strictly on diagnosis. Mr. McKinney added that a problem does sometimes arise when a physician orders several tests

such as chest x-rays and cat scan and then says that he will come see the patient.

Responding to a question, Mr. McKinney stated that the total capitation payment to MHS is based on the number of people in the managed care program.

Tim Kennedy (Hall, Render, Killian, Heath & Lyman) stated that the status of the patient in the emergency room is only half the problem. At some time, the hospital is required to get post-care certification, and a problem occurs when the primary care physician (PCP) does not respond. Consequently, the hospital and the emergency room do not get paid. Second, another problem can occur regarding post-stabilization care when the primary care physician can direct the care of the patient. However, by law the PCP has one hour to respond to the emergency room physician after the PCP has been notified that the patient has been stabilized. If there is no response within the one-hour time frame, the emergency room physician is allowed to direct the initial post-stabilization care of the patient.

Dr. Gutwein stated that sometimes emergency rooms are paid a triage fee, but this is not appropriate. Dr. Gutwein recommended that there not be a triage fee.

Cost-Based Reimbursement of Community Health Centers (CHC) - Lou Belch, KWK Management Group, introduced the issue of cost-based reimbursement of CHC's. He stated that two years ago legislation was enacted requiring cost-based reimbursement, and he was asking that those statutory provisions be continued.

Rep. Crawford asked that OMPP provide an assessment of the impact of that law on the issues presented at this meeting, especially relating to an increase in Medicaid reimbursement for physicians and to reimbursement rates for waiver services.

Mr. Jim Leich, Indiana Homes for the Aging, stated that there was a need to move the inflation factor up in the case-mix reimbursement methodology.

Sen. Miller requested that staff look at other states as to how their Medicaid programs are organized and administered and how those programs compare with OMPP in Indiana.

Rep. Brown requested that staff draft a bill for future consideration that would reestablish the Committee on Medicaid Oversight as a permanent committee.

In addition to documents presented during the meeting, a document from OMPP providing information requested by the Committee at the first meeting was distributed to Committee members in advance (see Exhibit 17).

There being no further business to conduct, the meeting was adjourned at 1:30 p.m.